IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

LISA ETKIN	:	CIVIL ACTION
	:	
	:	
v.	:	
	:	
	:	
MERK & COMPANY, INC. and	:	
METROPOLITAN LIFE INSURANCE	:	
COMPANY	:	NO. 00-5467

MEMORANDUM AND ORDER

HUTTON, J. October 30, 2001

Presently before this Court is Defendant's Motion for Summary Judgment (Docket No. 9), Plaintiff's Response thereto (Docket No. 12), and Defendant's Reply Brief (Docket No. 16). For the foregoing reasons, Defendants' Motion for Summary Judgment is **GRANTED**.

I. BACKGROUND

On or about October 3, 2000, Ms. Etkin filed a Complaint under the Employee Retirement Income Security Act ("ERISA") in the Court of Common Pleas of Philadelphia County. Defendant filed a Notice of Removal on October 27, 2000. Defendant filed its Answer and Affirmative Defenses on November 6, 2000.

Plaintiff's Complaint appears to allege a single-count ERISA violation, under 29 U.S.C. § 1001 et. seq.. Specifically, Plaintiff claims that the Defendant acted in an arbitrary and capricious manner when it denied her claim for Long-Term Disability Benefits.

The factual allegations on which the Plaintiff bases her claim are as follows. Plaintiff was first employed with Merk & Company on July 24, 1995. See Pl.'s Resp. to Def.'s Mot. Summ. J. at 2. Plaintiff was hired as a Laboratory Technician, and her duties included recording research data in the virology field for Measles, Mumps, Rubella, and Varicella vaccines. Id. at 3. On April 21, 1997, Plaintiff assumed a new position as Assistant Medical Program Coordinator. Id.

A Performance Review dated February 22, 1999 was conducted assessing Plaintiff's work performance as Assistant Medical Program Coordinator from January of 1998 through November of 1998. Id. The report confirmed Plaintiff's deteriorating work performance and rated her overall performance as "Not Acceptable." See Pl.'s Resp. to Def.'s Mot. Summ. J. at 3. Plaintiff's last day of work was October 29, 1998. Id. at 4.

In August of 1996, Plaintiff underwent nasal surgery. Id. Thereafter, Plaintiff alleges that she experienced facial pain, head pain, sleep disturbances, neck pain, upper extremity

weakness, facial numbness, and jaw pain. Id. In the summer of 1997, Plaintiff was seen at the Mayo clinic by Dr. Kern, an otolaryngologist, and Dr. Kent, a neurologist. Id. Dr. Kern diagnosed the Plaintiff as having "Empty Nose Syndrome." Id. In August 1997, Plaintiff came under the care of Dr. Slavitt, an Otolaryngologist. Id. Dr. Slavitt memorialized that the Plaintiff suffered pain related to lifting, sleeplessness and facial pain. See Pl.'s Resp. to Def.'s Mot. Summ. J. at 4.

In December of 1998, Plaintiff began to see Dr. Petito, a neurologist. Id. An MRI conducted by Dr. Petito revealed several disk protrusions in Plaintiff's spine. Id. On March 2, 1999, Plaintiff visited Dr. William Holder, who certified that Plaintiff was able to work two hours per day. Id. Plaintiff also visited Dr. Bayno, an osteopath, on June 15, 1999. Id.

Plaintiff filed her claim for long term disability benefits on April 1, 1999. See Pl.'s Resp. to Def.'s Mot. Summ. J. at 5. Her application included, among other things, a statement by Dr. Slavitt that Plaintiff was totally disabled due to Empty Nose Syndrome. Id. Interviews were also conducted with both Plaintiff and Dr. Slavitt and included in the application file. Id.

Metropolitan Life Insurance Company ("MetLife"), who served as the Plan Administrator on behalf of Merk, hired Network Medical Review ("NMR") to perform a review of Plaintiff's medical

records. Id. at 6. A report dated September 17, 1999 was prepared and forwarded to MetLife. Id. The reviewing doctors were Dr. Turok, a neurologist, and Dr. McCulloch, a otolaryngologist. Id. MetLife then received the medical report of Dr. McCulloch and Dr. Turok on September 20, 1999. Id. In a letter dated September 29, 1999, Defendant notified Plaintiff that, based on the file review by Drs. Turok and McCulloch, her claim for long-term disability benefits was denied.

On or about April 30, 2001, Defendants Merk & Company, Inc., and Metropolitan Life Insurance Company filed a Motion for Summary Judgment. On June 28, 2001, Plaintiffs filed a response to Defendant's Motion. On July 30, 2001, Defendant filed a reply brief to Plaintiff's Response. The Court now considers these filings.

II. LEGAL STANDARD

A. Summary Judgment Standard

Rule 56(c) of the Federal Rules of Civil Procedure provides that summary judgment is appropriate if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c); see also Celotex Corp. v. Catrett, 477 U.S. 317, 322-23,

106 S. Ct. 2548 (1986). The party moving for summary judgment "bears the initial responsibility of informing the district court of the basis for its motion, and identifying those portions of 'the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any,' which it believes demonstrate the absence of a genuine issue of material fact." Celotex, 477 U.S. at 323. When the moving party does not bear the burden of persuasion at trial, as is the case here, its burden "may be discharged by 'showing'--that is, pointing out to the district court--that there is an absence of evidence to support the nonmoving party's case." Id. at 325.

Once the moving party has filed a properly supported motion, the burden shifts to the nonmoving party to "set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e). The nonmoving party "may not rest upon the mere allegations or denials of the [nonmoving] party's pleading," id., but must support its response with affidavits, depositions, answers to interrogatories, or admissions on file. See Celotex, 477 U.S. at 324; Schoch v. First Fidelity Bancorporation, 912 F.2d 654, 657 (3d Cir. 1990).

To determine whether summary judgment is appropriate, the Court must determine whether any genuine issue of material fact exists. An issue is "material" only if the dispute "might affect

the outcome of the suit under the governing law." Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248, 106 S. Ct. 2505 (1986). An issue is "genuine" only "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." Id. If the evidence favoring the nonmoving party is "merely colorable," "not significantly probative," or amounts to only a "scintilla," summary judgment may be granted. See id. at 249-50, 252; see also Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 586, 106 S. Ct. 1348 (1986) ("When the moving party has carried its burden under Rule 56(c), its opponent must do more than simply show that there is some metaphysical doubt as to the material facts." (footnote omitted)). Of course, "[c]redibility determinations, the weighing of the evidence, and the drawing of legitimate inferences from the facts are jury functions, not those of a judge." Anderson, 477 U.S. at 255; see also Big Apple BMW, Inc. v. BMW of N. Am., Inc., 974 F.2d 1358, 1363 (3d Cir. 1992). Moreover, the "evidence of the non-movant is to be believed, and all justifiable inferences are to be drawn in his favor." Anderson, 477 U.S. at 255; see also Big Apple BMW, 974 F.2d at 1363. Thus, the Court's inquiry at the summary judgment stage is only the "threshold inquiry of determining whether there is the need for a trial," that is, "whether the evidence presents a sufficient disagreement to

require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." Anderson, 477 U.S. at 250-52.

III. DISCUSSION

In its Motion For Summary Judgment, Defendants Merk and Company, Inc. and Metropolitan Life Insurance Company argue that the denial of Plaintiff's claim for long term disability benefits was neither arbitrary nor capricious. Plaintiff argues that, based on the evidence, the Defendant's denial of long term disability benefits was arbitrary and capricious. The Court hereafter considers each claim.

A. Introduction

The Employee Retirement Income Security Act ("ERISA") is a comprehensive statute enacted "to promote the interests of employees and their beneficiaries in employee benefit plans," Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 90, 103 S.Ct. 2890, 2896, 77 L.Ed.2d 490 (1983), and "to protect contractually defined benefits," Massachusetts Mutual Life Ins. v. Russell, 473 U.S. 134, 148, 105 S.Ct. 3085, 3093, 87 L.Ed.2d 96 (1985); see also 29 U.S.C. § 1001.

ERISA's framework ensures that employee benefit plans be governed by written documents and summary plan descriptions,

which are the statutorily established means of informing participants and beneficiaries of the terms of their plan and its benefits. See Hozier v. Midwest Fasteners, Inc., 908 F.2d 1155 (3d Cir. 1990); Confer v. Custom Engineering Co., 952 F.2d 41 (3d Cir.1991); Hamilton v. Air Jamaica, Ltd., 945 F.2d 74 (3d Cir. 1991), cert. denied, 503 U.S. 938, 112 S.Ct. 1479, 117 L.Ed.2d 622 (1992); 29 U.S.C. § 1022(a)(1).

B. ERISA Standard of Review

This action is governed by ERISA, 29 U.S.C. § 1001 et seq.. However, ERISA does not specify a standard of review applicable to actions brought by a plan participant alleging a denial of benefits. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989). In determining the appropriate standard of review, the Supreme Court in Firestone rejected the universal application of the arbitrary and capricious standard when reviewing an ERISA administrator's decision regarding benefits eligibility. Id. Rather, applying principles of trust law, the Firestone Court held that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Id.

The Firestone holding was interpreted by the Third Circuit in Luby v. Teamsters Health, Welfare & Pension Trust Funds, 944 F.2d 1176 (3d Cir.1991). Under Luby, where an administrator is granted discretionary authority to grant or deny benefits, the administrator's factual determinations as well as interpretations of the plan are reviewed under the arbitrary and capricious standard. Id. at 1183-84.

The Third Circuit has also held that, where a conflict of interest exists, a heightened standard of review should apply. See Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377, 378 (3d Cir. 1998). The Pinto Court addressed the conflict of interest that arises when an insurer both decides claims and pays benefits from its own assets because "the fund from which the monies are paid is the same fund from which the insurance company reaps its profits ..." Id. Therefore, in cases where an insurance company both determines claims and pays benefits from its own assets, the Pinto Court adopted a "sliding scale" method under which less deference applies if the conflict of interest impacted the claim determination. Id.

In the instant case, MetLife was the "Claims Administrator" for the long term disability ("LTD") benefits under the Plan when Plaintiff's claim was denied. See Def.'s Mot. Summ. J. App., Exh. B, M0035. However, MetLife did not issue an insurance policy to

fund the Plan and was not financially responsible for the payment of LTD benefits. See App., Exh. A at D25. Rather, the benefits were "self-funded" by Merk through a trust fund. See App. Exh. B, M0027, M0039.

The Plan documents confirm Merk's ability to delegate it's authority to the Claims Administrator. Specifically, the Plan states:

> Merk & Co., Inc., as Plan Administrator, has the exclusive discretionary authority to construe and interpret the provisions of the Plans, to make factual determinations, to decide all questions of eligibility for benefits, to determine the amount of such benefits, to resolve all issues arising in the administration, interpretation and/or application of the Plans, to correct any defects, reconcile any inconsistencies and supply any omission with respect to the Plans ... Merk and Co., Inc., as Plan Administrator, has reserved the right to delegate all or any portion of its discretionary authority ... to a representative (e.g. claims administrators) and such representative's decisions on such matters are final and conclusive.

See App. Exh. B, M0025.

In this case, Merk delegated its authority and discretion to MetLife. See App. Exh. B, M0035. It is apparent, therefore, that the clear and unambiguous language of the Plan gives authority to the Administrator to construe and interpret the Plan in making all eligibility determinations. Accordingly, this Court must apply the arbitrary and capricious standard of review in deciding whether the Defendant's decision to deny Plaintiff LTD benefits was appropriate.

Under the arbitrary and capricious standard of review, a court must uphold an administrator's interpretation of a plan, even if it disagrees with it, so long as "the administrator's interpretation is rationally related to a valid plan purpose and is not contrary to the plain language of the plan." Dewitt v. Penn-Del Directory Co., 106 F.3d 514, 520 (3d Cir.1997). "Simply put, under the arbitrary and capricious standard a court may not disturb a fiduciary's interpretation of the plan so long as it is reasonable." Keating v. Whitmore Mfg. Co., No. 97-4463, 1998 WL 372457, at *1 (E.D.Pa. June 4, 1998). Under the arbitrary and capricious standard, "the district court may overturn a decision of the Plan administrator only if it is 'without reason, unsupported by the evidence or erroneous as a matter of law.' " Abnathya v. Hoffmann-LaRoche, Inc., 2 F.3d 40, 45 (3d Cir.1993). This Court, therefore, must abide by these standards in determining whether Defendant's denial of Plaintiff's claim for LTD benefits was appropriate.

C. Plaintiff's Claims

In a letter dated September 29, 1999, the Defendant notified the Plaintiff that her application for long term disability benefits had been denied because she was not considered "disabled" as defined in the Disability Plan. Under the Plan language, LTD benefits are payable when a participant is

determined by the claims administrator to be "unable to perform all material aspects of your occupation during the eligibility period and during the first 24 consecutive months that benefits are paid under the Plan." App. Exh. B, M13. Next, after the 24-month term ends, ongoing benefits are predicated on the participant being "unable to engage in any gainful occupation, for which your training, education or experience would reasonably allow." Id. This denial was based on all information contained in the administrative file, including the medical report written by Dr. McCulloch and Dr. Turok on September 20, 1999.

The Plaintiff points to the following instances where she believes that the Defendant acted in an arbitrary and capricious manner: 1) MetLife did not use the correct job description in its review of her claim; 2) MetLife based its decision on an incomplete administrative record; and 3) MetLife's decision based on the record evidence was arbitrary and capricious. For the reasons that follow, this Court finds that Plaintiff's claims that the Defendant acted in an arbitrary and capricious manner are without merit.

Plaintiff first asserts that Defendant's decision was arbitrary and capricious because the wrong job title was used in reviewing her claim. Specifically, Plaintiff claims that the Defendant erroneously used the "Laboratory Technician" job

description, rather than the "Assistant Medical Program Coordinator" job description. However, the administrative record reflects that Plaintiff referred to her job description from 1995 to present as lab "technician/clinical coordinator." See App. Exh. A, D418-419. Moreover, the position of Assistant Medical Program Coordinator is essentially a clerical position that involves much less strenuous activity than that of a laboratory technician. It cannot be said, therefore, that the outcome of Plaintiff's claim would have been any different if the different job title was considered, or that the Defendant acted in an arbitrary and capricious manner in denying Plaintiff's claim based on the very job description the Plaintiff herself used.

Plaintiff makes several other allegations that the opinions of Dr. Turok, Dr. McCulloch, and Dr. Porter were biased, unreliable and incredible. This Court finds each of these claims to be without merit. For example, Plaintiff contends that the review was improper because MetLife relied on physicians who reviewed her records but did not perform a physical examination. However, the Third Circuit has recently affirmed a district court case holding that is was not arbitrary and capricious for an insurer to rely on evaluations by doctors who never examined the claimant. See Forchic v. Standard Insurance Co., No. 99-6132, 2001 U.S. App. LEXIS 6303 (3d Cir. March 27, 2001).

Specifically, the district court held that it is not improper to rely on the opinions of nonexamining physicians who had before them the entire record of medical evidence, more evidence than was available to any one doctor who saw plaintiff previously. Forchic v. Lippincott, et al., No. 98-5423, 1999 U.S. Dist. LEXIS 21419, at *44 (D. N.J. November 29, 1999).

The Plaintiff makes several other allegations in advancing her argument that Drs. McCulloch, Turok and Porter conducted a biased and unreliable review of her claim. Plaintiff attacks Dr. McCulloch's and Dr. Turok's assertion that there was not enough objective evidence to support Plaintiff's disability claim. However, the only objective evidence that the Plaintiff refers to is a spinal MRI. Plaintiff's claim was based on atrophic rhinitis and chronic sinusitis, both nasal disorders. See App. Exh. A at D399. Moreover, the MRI's were reviewed by both Dr. McCulloch and Dr. Turok along with a nerve conduction study showing no evidence of radiculopathy. See App. Exh. A at D253, 257 and 295.

The Plaintiff also attacks Dr. Porter's opinion that Dr. Kern's article, submitted to MetLife on September 20, 1999 for consideration, would not change Dr. McCulloch's opinion that the Plaintiff was not entitled to disability benefits. However, Dr. Porter stated that the Kern article would not change McCulloch's

opinion because “it is information which he would have already understood as an ENT specialist.” See App. Exh. A at D194. It cannot be said that this opinion by Dr. Porter is arbitrary or capricious. Rather, it is based on his own medical knowledge and his familiarity with the medical expertise of Dr. McCulloch.

The Plaintiff attempts to advance several other arguments that the Defendant’s decision was unreasonable. These claims, however, are not supported by the record evidence. MetLife reviewed the records and opinions of ten doctors, numerous test results, Plaintiff’s disability claim form, resume, job descriptions, performance reviews and her “activities of daily living” form. See App. Exh. A at D115, 116. Dr. McCulloch, a board certified otolaryngologist, stated “Ms. Etkin should be capable of doing all work-related responsibilities and no restrictions would need to be applied ...” Id. at D254. Dr. McCulloch further noted that there was no impairment with regard to the ability to work associated with Plaintiff’s nasal breathing disorder. Id.

Additional evidence supports the reasonableness of the Defendant’s decision. Dr. Turok, a board certified neurologist, stated “... there is insufficient evidence for Ms. Etkin to be considered impaired from a neurological standpoint.” Id. at D257. Moreover, a registered nurse, Ms. Wooside, reviewed Plaintiff’s

claim file and concluded independently that the denial of benefits was warranted. Id. at D126-129. Therefore, based on the above analysis, and applying the deferential arbitrary and capricious standard, it cannot be said that the Defendant's decision to deny the Plaintiff's claim was so unreasonable, and so contrary to the language and the purpose of the plan, to be considered arbitrary and capricious. Accordingly, the Defendant's Motion for Summary Judgment is granted.

The Court notes that the Plaintiff has attached several exhibits to her Response to Defendant's Motion for Summary Judgment, claiming that MetLife conducted an incomplete review because it did not consider the information in those exhibits. To determine whether the Defendant's claim was arbitrary and capricious, however, we must look to the record as a whole. See Mitchell v. Eastman Kodak Co., 113 F.3d 433, 440 (3d Cir. 1997). Under the arbitrary and capricious standard of review, the "whole" record consists of that evidence that was before the administrator when he made the decision being reviewed. Id. As the information contained in these exhibits was not before the administrative committee, it may not be considered by this Court

in determining whether the Defendant’s decision was arbitrary and capricious.

An appropriate Order follows.

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LISA ETKIN	:	CIVIL ACTION
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MERK & COMPANY, INC. and	:	
METROPOLITAN LIFE INSURANCE	:	
COMPANY	:	NO. 00-5467

O R D E R

AND NOW, this 30th day of October, 2001, upon consideration of Defendant Merk and Company, Inc. and Metropolitan Life Insurance Company's Motion for Summary Judgment (Docket No. 9), Plaintiff Lisa Etkin's Response (Docket No. 12), and Defendant's Reply (Docket No. 16), IT IS HEREBY ORDERED that Defendant's Motion for Summary Judgment is **GRANTED**.

BY THE COURT:

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HERBERT J. HUTTON, J.